Handout O: Jabari's Child Health Record

CHILD HEALTH RECORD: **FORM 2A, HEALTH HISTORY**

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER: _____

CHILD'S NAME: Jabari Williams SEX: M BIRTHDATE: 8/5/94

PERSON INTERVIEWED: Monique Williams DATE: 7/16/98 RELATIONSHIP: Mom

NAME OF INTERVIEWER: Kathy Hallissey TITLE: Healthaide

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?		X	
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?		X	
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?		X	
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?		X	
5. WHAT WAS CHILD'S BIRTH WEIGHT?			6 lbs., 8 oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?		X	
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?		X	
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?		X	
9. IS MOTHER PREGNANT NOW?	X		*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?	X		pneumonia (1), sickling crises (2)
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)*?		X	
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?	X		sickle cell disease, anemia

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUENT ____ SORE THROAT; ____ COUGH; ____ URINARY INFECTIONS OR TROUBLE URINATING; ____ STOMACH PAIN, VOMITING, DIARRHEA?		X	
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)*?	•	X	
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?		X	*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)*?	•	X	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?		X	
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	•	X	*If "yes" ask:* WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*	X		WHAT MEDICINE? Vitamin, penicillin, ibuprofen, Tylenol/codeine *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? yes HOW OFTEN?
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?	X		(PHYSICIAN'S NAME: Mary Lafferty)
21. HAS CHILD HAD: ___ BOILS. X CHICKENPOX. ___ ECZEMA. ___ GERMAN MEASLES. ___ MEASLES. ___ MUMPS. ___ SCARLET FEVER. ___ WHOOPING COUGH?	X		
22. HAS CHILD HAD: ___ HIVES. ___ POLIO?	•	X	
23. HAS CHILD HAD: ___ ASTHMA. ___ BLEEDING TENDENCIES ___ DIABETES. ___ EPILEPSY. ___ HEART/BLOOD VESSEL DISEASE. ___ LIVER DISEASE. ___ RHEUMATIC FEVER. X SICKLE CELL DISEASE?	• X		*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)*? a WHEN EATING ANY FOODS? _____ b WHEN TAKING ANY MEDICATION? _____ c WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? _____	•	X	*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25 *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES?	X		DESCRIBE HOW: Tired a lot, pain, sick often
DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?	X		WHEN? tested at birth
26 ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES?		X	DESCRIBE:
DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			WHEN?

For use with Activity 3